Massachusetts Department of
Workforce Development
Division of Unemployment Assistance

# Notice of Grievance/Appeal

**Send to:** Division of Unemployment Assistance
Program Director, Medical Security Program
UI Central Operations
19 Staniford Street – 5th Floor
Boston, MA 02114

I appeal the following decision made by the Medical Security Program regarding the following:

- ☐ Eligibility for Coverage
- ☐ Effective/Start Date
- ☐ Retroactive Reimbursement
- ☐ Claim Allowance or Rejection
- ☐ Termination of Coverage
- ☐ Other (**please specify below**)

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I am appealing for the following reasons. (**Be specific. Attach extra documentation if necessary.**)

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I hereby authorize Blue Cross and Blue Shield of Massachusetts to release any relevant documentation, including claims information, to the Commonwealth of Massachusetts Division of Unemployment Assistance to assist in the review process.

Name: _____ Social Security Number: _____
(Please Print Clearly)

Signature: _____ Date: _____

Daytime Telephone #: ( ) _____ - _____ Ext: _____